1

FOR STATE HEALTH DEPT.

M

X

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1034 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10304

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Rt. 1 and Kalmia Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Darlington
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First TAFT — Middle HOWARD — Last AKINS

4. DATE OF DEATH: Month September — Day 9 — Year 19 60

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 4 1913

9. AGE (In years last birthday): 50 47 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labors on farm

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Harford Co Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Granville Akins

14. MOTHER'S MAIDEN NAME: Flora Christy Harlington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 212-26-6957

17. INFORMANT: Lerina Webster — Address: Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Traumatic Injuries. — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

812 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Pedestrian struck by auto.

20c. TIME OF INJURY: Hour e.m. XXX — Month, Day, Year 9/9 19 60

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town): Bel Air — (County): Harford — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county):

DATE SIGNED: 9/12/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Int

22b. DATE THEREOF: 9/13/1960

22c. NAME OF CEMETERY OR CREMATORY: Green Spring Cem

22d. LOCATION (City, town, or country): Harford Co. (State): Md.

23. FUNERAL DIRECTOR: H D Bailey — ADDRESS: Darlington Md

24a. REC'D BY REGISTRAR: DATE OCT 3 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal ... in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10325 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10305

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 110 Stonleigh

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 110 Stonleigh
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Stanley — Middle — Last Beeman
4. DATE OF DEATH: Month September — Day 28, — Year 19 60

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 9, 1921
9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stanley G. Beeman
14. MOTHER'S MAIDEN NAME: Grace Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Grace Henderson 110 Stoneleigh Rd. Belair, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Subacute bacterial endocarditis — INTERVAL BETWEEN ONSET AND DEATH
430.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wm. V. Lovitt, Jr. M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Wm. V. Lovitt, Jr., M.D.
Address (Street, city, town, or county):
DATE SIGNED: 9/29/60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/3/60
22c. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
22d. LOCATION (City, town, or country) (State): Baltimore, Md.

23. FUNERAL DIRECTOR — ADDRESS: Ullrich Funeral Home 4210 Belair Rd. -6.
24a. REC'D BY REGISTRAR DATE OCT 3 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10346

CERTIFICATE OF DEATH

10306

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 1 Yr
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): US Army Hospital, Aberdeen Proving Ground, Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Quarters # 113 Aberdeen Proving Ground, Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle DAVID Last BELK

4. DATE OF DEATH: Month September Day 2 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 19, 1901

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): Richmond, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Rufus Belk (Deceased)

14. MOTHER'S MAIDEN NAME: Mary Frances Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI Sep 42 to Present

16. SOCIAL SECURITY NO.: 265-18-4308

17. INFORMANT: US Army Official Records Address: Hq., APG Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Disease of unknown etiology, manifested by obstructive jaundice, fever and hypotension
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
785.2
INTERVAL BETWEEN ONSET AND DEATH: 31 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September 2 19 60 to September 2 1960, that (I) (we) last saw the deceased alive on September 2 19 60, and that death occurred at 10:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Walter J. Dombkoski Capt MC M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2 September 1960

22c. PHYSICIAN'S NAME (Type): WALTER J. DOMBKOSKI, Captain, Mc

22d. ADDRESS: US Army Hospital Aberdeen Proving Ground, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-8-60

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d. LOCATION (City, town, or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wm. Cook Blight Inc. 6009 Harford Rd. Balto. 14.

25a. REC'D BY REGISTRAR DATE: SEP 7 '60

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10330 10307

1. PLACE OF DEATH
a. COUNTY: HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 9 hrs 19 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MAGNOLIA
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BABY Middle BOY Last BENNETT

4. DATE OF DEATH: Month SEPT Day 5 Year 1960

5. SEX: MALE

6. COLOR OR RACE: wh.

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-4-60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours 9 Min 19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDGAR M. BENNETT

14. MOTHER'S MAIDEN NAME: JANICE HARRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: EDGAR M. BENNETT Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity (24 wks. gestation)
DUE TO (b): Premature Separation of Placenta
DUE TO (c): Maternal Peritonitis Following Rupture of Appendix

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/4 1960 to 9/5 1960 that (I) (we) last saw the deceased alive on 9/5 1960; and that death occurred at 4:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9/5/60

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: Sept. 5, 1960

23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Hospital

23d. LOCATION (City, town, or county) (State): Havre de Grace Md

24. FUNERAL DIRECTOR'S SIGNATURE: Harry R Tully Administrator ADDRESS:

25a. REC'D BY REGISTRAR DATE: SEP 9 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Kress

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

20711912 VO

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10347

Reg. Dist. No. 10308

1. PLACE OF DEATH
a. COUNTY: Hartford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
c. LENGTH OF STAY IN 1b: 6 wk.
d. NAME OF HOSPITAL OR INSTITUTION: 445 Emmerton Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Hartford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Edgewood
d. STREET ADDRESS: 445 Emmerton Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sidor — Middle — Last Boiko

4. DATE OF DEATH: Month Sept — Day 27 — Year 1960

5. SEX: Male
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 4 1888
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor.
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wasilevich Boiko
14. MOTHER'S MAIDEN NAME: ? Boiko

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Anna Satzik — Address: 445 Emmerton Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Prostate Gland — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1777 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/20/60, 19____, to 9/26, 1960, that I last saw the deceased alive on 9/26, 1960, and that death occurred at 5 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN: Elaine Kalan M.D. — ADDRESS (Street, city or town, state): 966 Edgewood Rd — DATE SIGNED: 9/27/60

PHYSICIAN'S NAME (Type)

4/27/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: SEPT 30 1960
22c. NAME OF CEMETERY OR CREMATORY: MORELAND MEMORIAL PARK
22d. LOCATION (City, town, or county): TAYLOR AVE (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Deppel Bros — ADDRESS: 1800 E. Lombard St.

24a. REC'D BY REGISTRAR DATE: SEP 28 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krupa

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10331

CERTIFICATE OF DEATH

10309

Item 6 dilmer 1-9-12-60 et

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDGEWOOD
d. STREET ADDRESS: SRB - Box 400 SINGER RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible] — Middle [illegible] — Last [illegible]

4. DATE OF DEATH: Month [illegible] Day 4 Year 19[illegible]

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 3-9-[illegible] 1883
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Minnick
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Son — Elmer BEANUM — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral — Embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Auricular fibrillations, Chronic — 2 years
DUE TO (c): Arteriosclerotic Cardiovascular disease — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Sept. 4 19[illegible] to Sept. 4th 1960 that (I) (we) last saw the deceased alive on Sept. 4th 1960 and that death occurred at 11 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Sept. 4th 1960
22c. PHYSICIAN'S NAME (Type): EDWARD C. LOO, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE THEREOF: Sept. 5 1960
23c. NAME OF CEMETERY OR CREMATORY: Dellinger & Son F.H.,
23d. LOCATION (City, town, or county) (State): Woodstock, Shenandoah, Va.,

24. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas Jr — ADDRESS: Abingdon, Md.
25a. REC'D BY REGISTRAR DATE: SEP 7 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10348

CERTIFICATE OF DEATH

10310

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 16 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAVRE DE GRACE R.D. # 1
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First LILLIAN Middle ELIZABETH Last CARLILE
4. DATE OF DEATH: Month SEPT Day 13 Year 1960

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC. 2, 1879
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): BALTO MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CAPT THOMAS BOWLING
14. MOTHER'S MAIDEN NAME: JULIA FLEMING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: EDGAR M. CARLILE Address: HAVRE DE GRACE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Cardiac Insufficiency — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Chronic Myocarditis
DUE TO (c): Arterio Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
723.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7/4, 19 58, to 9-12, 1960, that (I) (we) last saw the deceased alive on 9/16, 1960, and that death occurred at 4 PM, from the causes and on the date stated above

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 9/16/60
22c. PHYSICIAN'S NAME (Type): —
22d. ADDRESS: —

23a. BURIAL CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Sept. 16, 1960
23c. NAME OF CEMETERY OR CREMATORY: ROCK RUN CEM.
23d. LOCATION (City, town, or county) (State): HARFORD CO. MD.

24. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell
ADDRESS: HAVRE DE GRACE, MD.
25a. RECEIVED BY REGISTRAR DATE: SEP 16 '60
25b. REGISTRAR'S SIGNATURE: Carlton S. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10311

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
c. LENGTH OF STAY IN 16: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Recreation Hall, Battle St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Joppa
d. STREET ADDRESS: Mandeville Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LEVI Middle E. Last CHASE
4. DATE OF DEATH: Month September Day 17 Year 1960
5. SEX: Male
6. COLOR OR RACE: C.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 16 1933
9. AGE (In years last birthday): 27 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ernest Chase
14. MOTHER'S MAIDEN NAME: Ada Kay
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charlotte Chase 1679 Cliftview Ave Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 981X Gunshot Wounds of Chest
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): shot during altercation
20c. TIME OF INJURY Hour 7:30 p.m. Month, Day, Year Sept. 17 1960
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hall
20f. (City or town) Edgewood (County) Harford (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
DATE SIGNED: 9/18/60 (State)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9-22-60
22c. NAME OF CEMETERY OR CREMATORY: Mt Cubery
22d. LOCATION (City, town, or country): md

23. FUNERAL DIRECTOR: Geo. S. Kelson ADDRESS: 1348 N. Calhoun St
24a. REC'D BY REGISTRAR DATE: SEP 22 '60
24b. REGISTRAR'S SIGNATURE: Cullen S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10350 **CERTIFICATE OF DEATH** Reg. Dist. No. 10312

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Fallston
c. LENGTH OF STAY IN 1b: 24 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Does not apply

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Fallston
d. STREET ADDRESS: Fallston Rd
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Susan — Middle: Catherine — Last: Cochran

4. DATE OF DEATH: Month: September — Day: 1 — Year: 19[illegible]

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 29, 19[illegible]
9. AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Balto. Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Stroh
14. MOTHER'S MAIDEN NAME: Alberta Hoak

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-16-7449
17. INFORMANT: Husband (Thomas) — Address: Fallston, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Carcinomatosis, metastatic — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO (b): from Primary Carcinoma of Breast — 5 years
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): does not apply
20c. TIME OF INJURY Month, Day, Year, Hour a. m. / p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 5th, 19[illegible], to September 1960, that I last saw the deceased alive on September 1st, 19[illegible], and that death occurred at [illegible] M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James F. Wisley Jr. M.D. — ADDRESS (Street, city or town, state): Hooks Mill Rd, Fallston, Md — DATE SIGNED: Sept 9th 1960
PHYSICIAN'S NAME (Type): James F. Wisley, Jr. M.D. — Hooks Mill Rd, Fallston, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 14/1960
22c. NAME OF CEMETERY OR CREMATORY: St Johns Catholic
22d. LOCATION (City, town, or county) (State): Hyde, Baltimore Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Martin H. Kurtz — ADDRESS: Jarrettsville, Md
24a. REC'D BY REGISTRAR DATE: SEP 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10332

CERTIFICATE OF DEATH

10313

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 24 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
d. STREET ADDRESS: R.D #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Judson — Middle: T — Last: Comer

4. DATE OF DEATH: Month: 9 — Day: 9 — Year: 1960

5. SEX: Male — **6. COLOR OR RACE**: White — **7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐ — **8. DATE OF BIRTH**: 8/27/60. — **9. AGE** (In years last birthday): yrs — IF UNDER 1 YEAR: Months: Days: 13 — IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home — **10b. KIND OF BUSINESS OR INDUSTRY**: Infant — **11. BIRTHPLACE** (State or foreign country): Md. — **12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

13. FATHER'S NAME: Richard Comer. — **14. MOTHER'S MAIDEN NAME**: Doris Davis.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): / (If yes, give war or dates of service): / — **16. SOCIAL SECURITY NO.**: / — **17. INFORMANT** Address: Doris A. Comer.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): SEPTICEMIA - BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): CONGENITAL HEART DISEASE

7545

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a). — **19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER) — **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19 — **20d. INJURY OCCURRED** While at work ☐ Not while at work ☐ — **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 9-8 . 1960, to 9-9 . 1960 that (I) (we) last saw the deceased alive on 9-9 = 1960, and that death occurred at 9.50A.M. from the causes and on the date stated above

22a. SIGNATURE: Gunther D. Hirsch, M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — **22b. DATE SIGNED**: 9-10 60

22c. PHYSICIAN'S NAME (Type): GUNTHER D HIRSCH — **22d. ADDRESS**: 421 CONGRESS AV. HAVRE DE GRACE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **23b. DATE THEREOF**: 9/12/60 — **23c. NAME OF CEMETERY OR CREMATORY**: Bel Air Memorial Gds. — **23d. LOCATION** (City, town, or county) (State): Bel Air Maryland.

24 FUNERAL DIRECTOR'S SIGNATURE: John F. Garrung — **ADDRESS**: aberdeen, maryland, — **25a. REC'D BY REGISTRAR** DATE: SEP 14 '60 — **25b. REGISTRAR'S SIGNATURE**: Arthur S. Kruse

20713 3XV5

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10351

CERTIFICATE OF DEATH

10314
Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
c. LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Belair & Mountain Rd.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a STATE: Md. b COUNTY: Harf.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
d STREET ADDRESS: Belair & Mountain Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Ella	Gertrude	Diehlman	9	18	19 60

5 SEX	6. COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white		Dec. 20, 1887	73 yrs.				

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Polk Co. Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph T. Pike	Nancy Christian

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
		Mrs. Leora E. Purdum

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis → hypostatic congestion - approx 12hrs

DUE TO (b) arteriosclerosis - general

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: — (for b)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): general cachexia from debilitating arthritis.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A

20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 2, 1960, to Sept 18, 1960, that I last saw the deceased alive on Sept. 18, 1960, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Warren R. Lesch M.D. — ADDRESS (Street, city or town, state): 2025a Main-Belair, Md. — DATE SIGNED: 9/19/60

PHYSICIAN'S NAME (Type): Warren R. Lesch

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	9/21/60	Gardens of Faith	Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b REGISTRAR'S SIGNATURE
Leonard J. Ruck 5305 Harford Rd.	SEP 22 '60	Clifton S. Kruse

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10333 10315

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
c LENGTH OF STAY IN 1b 1 day
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARF[illegible] MEMORIAL H[illegible]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
d STREET ADDRESS (Or location) [illegible] FIRST [illegible] e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]
4. DATE OF DEATH Month SEPT Day 4 Year 19[illegible]

5 SEX MALE
6 COLOR OR RACE Wh.
7 MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4/16/1887
9 AGE (In years last birthday) 73 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer [illegible]
10b KIND OF BUSINESS OR INDUSTRY Unknown
11. BIRTHPLACE (State or foreign country) ITALY
12 CITIZEN OF WHAT COUNTRY? ITALY

13. FATHER'S NAME FRANK D[illegible]
14 MOTHER'S MAIDEN NAME ANGELA MARC[illegible]A

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)
16 SOCIAL SECURITY NO Unknown
17. INFORMANT [illegible] Address [illegible] By M. Harold Shaw

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
581.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on 9-4-1960, and that death occurred at 5:45 A.M., from the causes and on the date stated above

22a SIGNATURE E. J. Simoni M D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED
22c. PHYSICIAN'S NAME (Type) E. J. SIMONI
22d. ADDRESS HAVRE DE GRACE

23a BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF 9/7/60
23c NAME OF CEMETERY OR CREMATORY Mt. Erin
23d LOCATION (City, town, or county) (State) Havre de Grace Md.

24 FUNERAL DIRECTOR'S SIGNATURE Thomas J. Shaw ADDRESS Havre de Grace Md
25a REC'D BY REGISTRAR DATE SEP 9 '60
25b REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10352

CERTIFICATE OF DEATH

10316

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 15 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital, Aberdeen Proving Ground, Md

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 15 Gunnison Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: MINNIE — Middle: E. — Last: FORTIN

4. DATE OF DEATH: Month: September — Day: 1 — Year: 19 60

5 SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 17, 1910

9. AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife Accountant

10b. KIND OF BUSINESS OR INDUSTRY: N/A U.S. Govt.

11 BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Charlie Anderson

14. MOTHER'S MAIDEN NAME: Fannie Lovell

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1943-1945

16 SOCIAL SECURITY NO.: 408-05-7003

17 INFORMANT: Robert Fortin (husband) — Address: 15 Gunnison Drive, Aberdeen, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Encephalomalacia — INTERVAL BETWEEN ONSET AND DEATH: 47 hours

517 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Anoxia and cardiac arrest — 47 hours

DUE TO (c): Tracheobronchio spasm — 47 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY: Month, Day, Year, Hour, a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 29, 1960 to Sep 1, 1960 that (I) (we) last saw the deceased alive on Sep 1, 1960, and that death occurred at 9:35 AM from the causes and on the date stated above

22a SIGNATURE: Julio B. Acosta Capt MC — M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: Sep 1, 1960

22c. PHYSICIAN'S NAME (Type): JULIO B. ACOSTA, Captain, MC

22d. ADDRESS: US Army Hosp/ Aberdeen Proving Ground, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9/6/60

23c NAME OF CEMETERY OR CREMATORY: Balto. National Cemetery

23d LOCATION (City, town, or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Tarring Funeral Home, Aberdeen, Md.

John G. Tarring

25a REC'D BY REGISTRAR DATE: SEP 6 '60

25b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10353 **CERTIFICATE OF DEATH** Reg. Dist. No. 10317

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Darlington
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Conowingo Village

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Belair
d. STREET ADDRESS: R.D. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUSIE Middle ELIZABETH Last GRACE

4. DATE OF DEATH: Month Sept. Day 16, Year 19 60

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 15, 1891

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Arthur Barker, Conowingo, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arteriosclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 4, 1959, to Sept. 16, 1960, that I last saw the deceased alive on Sept 15, 1960, and that death occurred at 9 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips MD M.D. ADDRESS (Street, city or town, state): DARLINGTON, MARYLAND DATE SIGNED: 9/18/60

PHYSICIAN'S NAME (Type): Dudley Phillips MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-19-1960

22c. NAME OF CEMETERY OR CREMATORY: Oak Grove

22d. LOCATION (City, town, or county) (State): Fountain Green, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Harbine, ADDRESS: Delta, Penna.

24a. REC'D BY REGISTRAR DATE: SEP 20 '60

24b. REGISTRAR'S SIGNATURE: Calvin L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10318

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: BALTO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PARKVILLE
d. STREET ADDRESS: 7814 OAK AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MATTIE Middle MAY Last HAMBURY

4 DATE OF DEATH: Month SEPTEMBER Day 6 Year 1960

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Aug 30, 1881
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: THOMAS G. GROVES
14. MOTHER'S MAIDEN NAME: VIRGINIA PHILLIPS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: MR ROLAND T. HAMBURY — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bronchopneumonia	1 wk
DUE TO (b)	Arteriosclerotic Cardiovasc. Disease	Years
DUE TO (c)	Old Left Hip Fracture & decubitus ulcers	4 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a m p. m 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 30, 1960 to Sept ____, 19____, that (I) (we) last saw the deceased alive on Sept 6 19 60, and that death occurred at 10:30 P M, from the causes and on the date stated above.

22a SIGNATURE: W.H. Sadowsky M D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED
22c PHYSICIAN'S NAME (Type): W.H. SADOWSKI M D
22d. ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 9-10-60
23c NAME OF CEMETERY OR CREMATORY: Parkwood Mem
23d LOCATION (City, town, or county) (State): Balto Md

24 FUNERAL DIRECTOR'S SIGNATURE: Lemmon & Tuck
ADDRESS: 5305 Harford
25a. REC'D BY REGISTRAR DATE SEP 9 '60
25b REGISTRAR'S SIGNATURE: Clifton S. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10335

CERTIFICATE OF DEATH

10319

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Blair
d. STREET ADDRESS: 404 Hickory St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Fielder — Middle: Lee — Last: Henderson

4 DATE OF DEATH: Month: Sept. — Day: 15 — Year: 1960

5 SEX: Male

6 COLOR OR RACE: White

7. ~~MARRIED~~ ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Nov 4 1906

9 AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Radio Operator

10b KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Grayson Co. Ky.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Charles Henderson

14. MOTHER'S MAIDEN NAME: Lizzie Lucke

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No

16 SOCIAL SECURITY NO: 219-01-5938

17 INFORMANT: Address: Mrs. Hazel Henderson Box 95 Md. North East

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fulminant bronchopneumonia, bilateral
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 8 days.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral thrombosis.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from Sept 11, 19 60 to Sept 15, 1960, that (I) (we) last saw the deceased alive on Sept 15th, 1960, and that death occurred at 7:40 A.M., from the causes and on the date stated above

22a SIGNATURE: Edward E. Loo, M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: Sept. 15th. 60

22c PHYSICIAN'S NAME (Type): Edward E. Loo, M.D.

22d ADDRESS: 211 N. Union Ave, Havre de Grace Md

23a BURIAL, CREMATION, REMOVAL (Specify)

23b DATE THEREOF: Sept 16, 1960

23c NAME OF CEMETERY OR CREMATORY: Sharon Memorial Park

23d LOCATION (City, town, or county) (State): North Carolina

24 FUNERAL DIRECTOR'S SIGNATURE: Otis E. Bailey — ADDRESS: Darlington, Md.

25a. REC'D BY REGISTRAR DATE: SEP 19 '60

25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10335 **CERTIFICATE OF DEATH** 10320

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 13 HRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABERDEEN
d. STREET ADDRESS: RD #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARVEY Middle W Last HERBERT

4. DATE OF DEATH: Month September Day 26 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Aug. 14, 1896

9 AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.,

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George M. Herbert

14 MOTHER'S MAIDEN NAME: Mary E. Shaffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 215-01-1623

17. INFORMANT: Lollie Herbert Address: Aberdeen R.D., Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Coronary Occlusion Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO (b): Coronary arteria Sclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from January 1959 to Sept 27 1960 that (I) (we) last saw the deceased alive on Sept 27 1960 and that death occurred at 11:45 A.M. from the causes and on the date stated above

22a SIGNATURE: Andre Weiss M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ANDRE WEISS

22d. ADDRESS: 114 W. Bel Air Avenue Aberdeen, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: Sept. 30, 1960

23c NAME OF CEMETERY OR CREMATORY: Parkwood

23d LOCATION (City, town or county) (State): Baltimore Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE: Edward C. Wiltrout Jr.

ADDRESS: Abingdon, Md.,

25a REC'D BY REGISTRAR DATE: OCT 3 '60

25b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10354

CERTIFICATE OF DEATH

10321

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital, Aberdeen Proving Ground, Md

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen
d. STREET ADDRESS # 127 Alton Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KARON Middle DENISE Last HONEYCUTT
4. DATE OF DEATH: Month September Day 3 Year 19 60
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 1, 1960
9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Norwood Clyde Honeycutt
14. MOTHER'S MAIDEN NAME: Claudia Priscilla Jackson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A (If yes, give war or dates of service) N/A
16. SOCIAL SECURITY NO.: N/A
17. INFORMANT: Father — Address 127 Alton Street Aberdeen, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 47 hours
776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sep 1, 1960 to Sep 3, 1960 that ☒ (we) last saw the deceased alive on Sep 3 19 60 and that death occurred at 8:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Mark Eisenstein M.D.
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: Sep 3, 1960
22c. PHYSICIAN'S NAME (Type): MARK EISENSTEIN
22d. ADDRESS: US Army Hospital Aberdeen Proving Ground, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/6/60
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery
23d. LOCATION (City, town, or county) (State): Havre de Grace, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: John D. Tarring — Address: Tarring Funeral Home Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE SEP 8 '60
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

John G. Tarring 20502 12 X VI

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10355

Reg. Dist. No. 10322

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
c. LENGTH OF STAY IN 1b: 15 yrs.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS: Reckord Rd.,
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First George — Middle Marshall — Last Hooper
4. DATE OF DEATH: Month Sept. — Day 19 — Year 1960
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Mar. 4, 1898
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: House
11. BIRTHPLACE (State or foreign country): Reckordville, Md.,
12. CITIZEN OF WHAT COUNTRY? U.S.A.,

13. FATHER'S NAME: Christopher Hooper
14. MOTHER'S MAIDEN NAME: Mary Orem

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218 07 6024
17. INFORMANT: Martha Hooper, Address: Joppa R/D. Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute and Chronic Bronchitis — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Peripheral Vascular Disease — Intra abdominal Cancer
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Site undetermined
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____ 19__ to Sept. 19, 1960, that I last saw the deceased alive on Sept. 18, 1960, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: William A. Tyson M.D. — ADDRESS (Street, city or town, state): Kingsville, Md. — DATE SIGNED: 9-19-60

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept. 22, 60
22c. NAME OF CEMETERY OR CREMATORY: Fork Baptist
22d. LOCATION (City, town, or county) (State): Fork, Balto., Md.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas Jr.
ADDRESS: Abingdon, Md.,
24a. REC'D BY REGISTRAR DATE: SEP 26 '60
24b. REGISTRAR'S SIGNATURE: Clinton E. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10337

CERTIFICATE OF DEATH

10323

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY: Harford — b. STATE: Maryland

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE: Maryland — b. COUNTY: Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace, Md.

d. STREET ADDRESS: 505 S. Washington

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jane — Middle: Jackson — Last: Johnson

4. DATE OF DEATH: Month: 9 — Day: 18 — Year: 60

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 7, 1866

9. AGE (In years last birthday): 93 yrs

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Principio Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Jackson

14. MOTHER'S MAIDEN NAME: Rachel Caldwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Charles Pearson — Address: 505 S. Washington Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PULMONARY OEDEMA — INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR

DUE TO (b): CEREBRAL THROMBOSIS — 1 DAY

DUE TO (c): CHRONIC MYOCARDITIS & HYPERTENSION — 10 YEARS

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CHRONIC INTERSTITIAL NEPHRITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from November, 1934, to September, 1960, that I last saw the deceased alive on September 18, 1960, and that death occurred at ____ M, from the causes and on the date stated above

ACTUAL SIGNATURE: Frank Wolbert M.D. — ADDRESS (Street, city or town, state): 200 North Union Avenue — DATE SIGNED: 9/19/60

PHYSICIAN'S NAME (Type): FRANK WOLBERT MD — Havre de Grace Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): — 22b. DATE THEREOF: 9/21/60 — 22c. NAME OF CEMETERY OR CREMATORY: Angel Hill — 22d. LOCATION (City, town, or county) (State): Havre de Grace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Lamotte & Son — ADDRESS: Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: SEP 22 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur J. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10326 **CERTIFICATE OF DEATH** Reg. Dist. No. 10324

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BelAir
c. LENGTH OF STAY IN 1b 4 years

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BelAir

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION 102 West Belcrest Road

d. STREET ADDRESS 102 West Belcrest Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Bessie Middle Irene Last Mattern

4. DATE OF DEATH Month September Day 24th, Year 1960

5. SEX female
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 27,1886
9. AGE (In years last birthday) 74 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pennsylvania
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles W.Miller
14. MOTHER'S MAIDEN NAME Susan Masenheimer

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 716-12-7451A
17 INFORMANT A.O.Mattern,Sr., Address same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 15 min.

DUE TO (b) Coronary Atherosclerosis — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hiatal hernia, obesity

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1957, to Sept. 24, 1960, that I last saw the deceased alive on Sept. 24 1960, and that death occurred at 12:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Charles Lukeson M.D. ADDRESS (Street, city or town, state) 1265 S. Main, Bel Air, Md DATE SIGNED 9/24/60

NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 9/27/60
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery
22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Brooks Bradley, Inc., Dundalk 22, Md
24a. REC'D BY REGISTRAR DATE SEP 27 '60
24b. REGISTRAR'S SIGNATURE Arthur L Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10338

10325

1 PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b: 7 da 1 6
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: [illegible]

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 [illegible]
d. STREET ADDRESS: [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible] Middle J. Last [illegible]

4. DATE OF DEATH: Month [illegible] Day [illegible] Year 19[illegible]

5 SEX: [illegible] | 6 COLOR OR RACE: [illegible] | 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8 DATE OF BIRTH: [illegible] | 9 AGE (In years last birthday): [illegible] yrs | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: [illegible] S [illegible]
14. MOTHER'S MAIDEN NAME: [illegible] Miltonberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: [illegible]
17. INFORMANT: Husband Address: [illegible]

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Cervix

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible] to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above

22a SIGNATURE: Dudley Phillips MD M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED
22c PHYSICIAN'S NAME (Type) Dudley Phillips MD
22d. ADDRESS: DARLINGTON, MARYLAND 9/5/60

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9/8/60
23c NAME OF CEMETERY OR CREMATORY: Hephzibah Baptist Cem.
23d LOCATION (City, town, or county) (State): Coatsville, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: John G. Tarring — Tarring Funeral Home, Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE: SEP 8 '60
25b REGISTRAR'S SIGNATURE: Arthur L. Kraus

John G. Tarring

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10327 10326

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: MARYLAND 25 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): American Restaraunt (S. Main St.)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 126 N. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert; Middle: Richardson; Last: Norris

4. DATE OF DEATH: Month: September; Day: 10; Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-12-95

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months, Days IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William HENry Norris

14. MOTHER'S MAIDEN NAME: Margaret Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 206-10-2739

17. INFORMANT (Brother): Mr. HENry Norris Address: 133 South Sumner Ave. Scranton 4, PENNsylvania

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C. Palmer M.D.

Address (Street, city, town, or county):

DATE SIGNED: 9-10-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 13, 1960

22c. NAME OF CEMETERY OR CREMATORY: St. Ignatius Cemetery

22d. LOCATION (City, town, or country) (State): Hickory, Harford Co., Maryland

23. FUNERAL DIRECTOR ADDRESS: Joseph W. Foster W. Broadway + Williams St. Bel Air, Maryland

Joseph W. Foster

24a. REC'D BY REGISTRAR DATE: SEP 13 '60

24b. REGISTRAR'S SIGNATURE: Chilton L. Hood

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10339

CERTIFICATE OF DEATH

10327

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 9 hrs 15 min
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X ABINGDON
Box 12
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JANICE — Middle M — Last NORTON

4. DATE OF DEATH: Month SEPT — Day 24 — Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/17/60

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months 2 — Days 7
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: KENNETH NORTON

14. MOTHER'S MAIDEN NAME: MILDRED HARRIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT FATHER Address: KENNETH NORTON

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Pneumonitis
DUE TO
(b):
DUE TO
(c): Rhinopharyngitis & Bronchitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

470X

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastro enteritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 23, 1960, to Sept 24, 1960, that (I) (we) last saw the deceased alive on Sept 24 19 60, and that death occurred at 4:40 P.M., from the causes and on the date stated above

22a. SIGNATURE: George T. Stansbury M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): George T. Stansbury

22d. ADDRESS: 524 Revolution St. Havre de Grace, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: Sept. 26, 1960

23c. NAME OF CEMETERY OR CREMATORY: John Wesley

23d. LOCATION (City, town, or county) (State): Abingdon, Harford, Md.,

24. FUNERAL DIRECTOR'S SIGNATURE: Howard L. Williams

ADDRESS: Abingdon, Md.,

25a. REC'D BY REG STRAR DATE: SEP 29 '60

25b. REGISTRAR'S SIGNATURE: C. Wm. S. Kemp

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

Item 2C Film 27,1 5-29-

1

10328

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10340

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace

c. LENGTH OF STAY IN 1b: D.O.A.

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE: Maryland b. COUNTY: Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun - Rural

d. STREET ADDRESS:

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Helen Middle: Elaine Last: ORR

4. DATE OF DEATH: Month: Sept. Day: 6 Year: 1960

5 SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug-30-1960

9. AGE (In years last birthday): yrs

IF UNDER 1 YEAR: Months: Days: 8 IF UNDER 24 HRS: Hours: Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b KIND OF BUSINESS OR INDUSTRY: —

11 BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: George M. Orr Jr.

14 MOTHER'S MAIDEN NAME: Helen Kaye

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. George Orr Jr. Address: Rising Sun Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): RESPIRATORY Failure — INTERVAL BETWEEN ONSET AND DEATH: 1hr

DUE TO (b): Aspiration of formula

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): Aspiration of formula

20c TIME OF INJURY Hour: 9:30 p m Month, Day, Year: 9-6-1960

20d INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f (City or town): Rising Sun (County): Cecil (State): Md

21 I certify that (I) (this hospital)/attended the deceased from 8/30 1960, to 9/6 1960, that (I) (we) last saw the deceased alive on 9/6 1960, and that death occurred at 1 P M, from the causes and on the date stated above.

22a SIGNATURE: Dudley Phillips MD

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED: 9/6/60

22c PHYSICIAN'S NAME (Type): Dudley Phillips MD

22d ADDRESS: Darlington, Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 9-9-1960

23c NAME OF CEMETERY OR CREMATORY: Darlington Cem.

23d LOCATION (City, town, or county): Darlington (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen ADDRESS: Rising Sun Md

25a REC'D BY REGISTRAR DATE: SEP 9 '60

25b REGISTRAR'S SIGNATURE: Arthur S. Kline

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10341

10329

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a COUNTY: HARFORD — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 13 HRS.
d NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: HARFORD MEMORIAL Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission)
o. STATE: Maryland
b COUNTY: HARFORD
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE 24
d. STREET ADDRESS: 418 Freedom
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle LEWIS Last PEACO
4 DATE OF DEATH: Month SEPTEMBER Day 15 Year 1960

5. SEX: MALE
6 COLOR OR RACE: Colored
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8 DATE OF BIRTH: April 23, 1900
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired): Bartender
10b KIND OF BUSINESS OR INDUSTRY: Night Club
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abron Henry PEACO
14. MOTHER'S MAIDEN NAME: SARAH FRENCH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown): no
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mr. Lloyd Peaco, Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Septicemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast

DUE TO (b): Rectal Abscess

DUE TO (c): Emphysematous Phlegmon of Scrotum

INTERVAL BETWEEN ONSET AND DEATH

692.6

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/10 1960, to 9/15 1960, that (I) (we) ast saw the deceased alive an 9/15 19 60, and that death accurred at 3:30 AM, from the causes and on the date stated abave

22a SIGNATURE: George T. Stansbury, M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 9/15/60
22c PHYSICIAN'S NAME (Type): George T. Stansbury
22d. ADDRESS: 569 Revolution St. Havre de Grace, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 9/17/60
23c NAME OF CEMETERY OR CREMATORY: St. James Cemetery
23d LOCATION (City town, or county) (State): Havre de Grace, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Elmer Bullock
ADDRESS: Havre de Grace
25a REC'D BY REGISTRAR DATE: SEP 20 '60
25b REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certif cate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

I

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10356

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10330

1. **PLACE OF DEATH**
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b: MARYLAND 20 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Ady Road

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS: Ady Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle E. Last Price

4. DATE OF DEATH: Month September Day 11 Year 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-30-75

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Mason

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Baltimore County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Price

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO —

16. SOCIAL SECURITY NO: 219-05-1905 A

17. INFORMANT (Daughter): Mrs. Mary F. Beck Address: 211 Georgia Avenue Glen Burnie, Maryland

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C. Palmer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 9-11-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 14, 1960

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or country) (State): Bel Air, Harford County, Maryland

23. FUNERAL DIRECTOR: Joseph W. Foster ADDRESS: W. Broadway & Williams St. Bel Air, Maryland

Joseph W. Foster

24a. REC'D BY REGISTRAR DATE: SEP 13 '60

24b. REGISTRAR'S SIGNATURE: Clarence L. Hance

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10342

CERTIFICATE OF DEATH

10331

1 PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 15 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen.
d. STREET ADDRESS R.F.D#3 Box 126.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Helen Middle Eva Last Rickey
4. DATE OF DEATH Month 9 Day 14 Year 1960
5. SEX Female
6. COLOR OR RACE White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH April 6, 1911
9. AGE (In years last birthday) 49 yrs
IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Wife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John H. Meyers
14. MOTHER'S MAIDEN NAME Elizabeth Linthicum.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address Morgan Richey Aberdeen, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PORTAL CIRRHOSIS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 4 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1957 to 9-14 1960, that (I) (we) last saw the deceased alive on 9-14 1960, and that death occurred at 3:45 P.M., from the causes and on the date stated above

22a. SIGNATURE Emmett D. Hirsh M.D.
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b. DATE SIGNED 9-15-60
22c. PHYSICIAN'S NAME (Type) Gunther D. Hirsh, M.D.
22d. ADDRESS 421 Congress Ave. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9/17/60
23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery
23d. LOCATION (City, town, or county) (State) Perryman, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring
ADDRESS Tarring Funeral Home Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE SEP 19 60
25b. REGISTRAR'S SIGNATURE Arthur S. Kuhns

John G. Tarring

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10357

CERTIFICATE OF DEATH

10332 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHITEFORD
c. LENGTH OF STAY IN 1b: 79 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MAIN

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHITEFORD
d. STREET ADDRESS: MAIN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First IDA — Middle MAY — Last ROSS

4. DATE OF DEATH: Month SEPT. — Day 12, — Year 1960

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 2-17-1881

9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): GLOUCESTER, VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM A. LEE

14. MOTHER'S MAIDEN NAME: MARY E. BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MRS. MARSHALL JONES, WHITEFORD, MD. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive C-V Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__ to Sept 12 19 60 that I last saw the deceased alive on Sept 11, 1960, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Josiah A. Hunt M.D. — ADDRESS (Street, city or town, state): Delta Pa. — DATE SIGNED: 9/13/60

PHYSICIAN'S NAME (Type): Josiah A Hunt, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 9-15-60

22c. NAME OF CEMETERY OR CREMATORY: SOUTHERN

22d. LOCATION (City, town, or county) (State): DUBLIN, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Watkins — ADDRESS: Delta, Pa.

24a. REC'D BY REGISTRAR DATE: SEP 15 '60

24b. REGISTRAR'S SIGNATURE: Clifton S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10383

10358

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY HARFORD — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Army Chemical Center

LENGTH OF STAY (In this place): 3 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Bldg 1536

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland — COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Army Chemical Center

STREET ADDRESS (If rural give location): Building 1536

3. NAME OF DECEASED (Type or Print): (First) JAI — (Middle) STOUT — (Last) STOCKHARDT

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1960 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married	1 Nov 1904	55 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Soldier	Army	Elwood, Indiana	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Philip E Stockhardt	Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Yes	WW II	163-01-0931	U. S. Army Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

421. IMMEDIATE CAUSE (A) Sudden Death

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Calcific aortic stenosis(autopsy)

DUE TO (C) Body released for autopsy by Dr. Gerald Palmer

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Deputy Medical Examiner, Harford County, Md.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5 Sep, 19 60, to 5 Sep, 19 60, that I last saw the deceased alive on ....., 19....., and that death occurred at 1200 M, from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Capt. Donald D. Haut M.D.	Army Chemical Center, Maryland	5 Sep 60

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9/12/60	Arlington Nat. Cemetery	Arlington, Va.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
SEP 13 '60		Wm. Cook Blight Inc. 6009 Harford Rd. (14)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10359

CERTIFICATE OF DEATH

10334 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill
c. LENGTH OF STAY IN 1b: 50 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Forest Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Henry — Last: Swam

4. DATE OF DEATH: Month: Sept. — Day: 6, — Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 11, 1877

9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired painter

10b. KIND OF BUSINESS OR INDUSTRY: Gen. painting

11. BIRTHPLACE (State or foreign country): Beckleyville, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Henry Swam

14. MOTHER'S MAIDEN NAME: Sarah Jane Painter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 218-32-5157

INFORMANT: Roy E. Swam — Address: Forest Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chr. cardiovascular disease — ? ?
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. , 1958, to Sept. 6 , 1960 that I last saw the deceased alive on Sept. 6 , 1960 , and that death occurred at 10:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: 9-7-60

PHYSICIAN'S NAME (Type): WILLARD P. HUDSON M.D. FOREST HILL, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/9/1960

22c. NAME OF CEMETERY OR CREMATORY: Centre

22d. LOCATION (City, town, or county) (State): Forest Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz — ADDRESS: Jarrettsville Md

24a. REC'D BY REGISTRAR DATE: SEP 9 '60

24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10328

CERTIFICATE OF DEATH

10335

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Emmorton Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Emmorton Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sarah Middle: V. Last: Tickle

4. DATE OF DEATH: Month: September Day: 21 Year: 1960

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-2-84
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Giles Co., Va.,
12. CITIZEN OF WHAT COUNTRY? U.S.A.,

13. FATHER'S NAME: Charles Hughes
14. MOTHER'S MAIDEN NAME: Sena Harrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs., A.P. Blevins, Bel Air, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Mesenchymoma — INTERVAL BETWEEN ONSET AND DEATH: 3 years

1977

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1-1 19 58 to 9-21 19 60 that I last saw the deceased alive on 9-20 19 60, and that death occurred at 12:55 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerald C Palmer M.D.
ADDRESS (Street, city or town, state): Bel Air, Md
DATE SIGNED: 9-21-60

PHYSICIAN'S NAME (Type): Gerald C Palmer MD

22a BURIAL CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: Sept 21, 60
22c. NAME OF CEMETERY OR CREMATORY: Givens Funeral Home
22d. LOCATION (City, town, or county) (State): Pearisburg, Giles., Va.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K McInnis Jr
ADDRESS: Abingdon, Md.,
24a. REC'D BY REGISTRAR DATE: SEP 23 '60
24b REGISTRAR'S SIGNATURE: Helen S Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10329 10336

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY: HARFORD — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR

LENGTH OF STAY (in this place): 2 YRS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: RESIDENCE 104 SHAMROCK RD

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: MARYLAND COUNTY: HARFORD

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR, MD.

STREET ADDRESS (If rural give location): 104 SHAMROCK RD.

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) AUGUST (Last) TINE

4. DATE OF DEATH (Month) SEPT (Day) 2 (Year) 1960

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
M	W	MARRIED	18 MAY '87	73 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHAUFFEUR

10b. KIND OF BUSINESS OR INDUSTRY: BALTO. SUN PAPERS

11. BIRTHPLACE (State or foreign country): BALTO, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN TINE

14. MOTHER'S MAIDEN NAME: ELIZABETH SCHNEIDER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.): NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-03-2832

17. INFORMANT & ADDRESS: SON: CHARLES TINE (SAME)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): CARDIO-RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS

ANTECEDENT CAUSE(S) DUE TO (B): ADVANCED CARCINOMA OF STOMACH (LINITIS PLASTICA) 4 MO.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: ADVANCED ARTERIOSCLEROSIS LEFT LEG AMPUTATED AT MID-THIGH — 9 YRS.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21e. INJURY OCCURRED White at work ☐ Not white at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from APR 10, 1957, to 2 SEPT, 1960, that I last saw the deceased alive on 1 SEPT, 1960, and that death occurred at 11:25 P.M, from the causes and on the date stated above.

SIGNATURE: H. P. Caldwell M.D — ADDRESS (Street, city, town, state): 401 Franklin St. Bel Air Md. — DATE SIGNED: 2 SEPT 60

23. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL — DATE THEREOF: 9/6/60 — NAME OF CEMETERY OR CREMATORY: ST PETERS CEM. — LOCATION (City, town, or county) (State): BALTIMORE MD.

24. REC'D BY REGISTRAR DATE: SEP 7 '60 — REGISTRAR'S SIGNATURE: Arthur S. Travis

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lassahn Funeral Home 1401 Belair Rd 6.

Item 7 File 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10337

CERTIFICATE OF DEATH

10360 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D. #2, Box 323

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air (Rural)
d. STREET ADDRESS: R.D. #2, Box 323
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ESTELLA Middle L. Last TODD
4. DATE OF DEATH: Month September Day 9 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 28, 1877
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John G. Lay
14. MOTHER'S MAIDEN NAME: Sallie Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Harley G. Hampton, Address RD. 2 Box 323 Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Gangrenous Decubitus Ulcers	1 month
DUE TO (b)	Fracture, Left Femoral Neck	3 months.
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fall from bed
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. June 1 1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Bel Air (County) Harford (State) Md

21. I certify that I attended the deceased from 10/14/53, 19____, to 9/9/60, 19____, that I last saw the deceased alive on 9/6/60, 19____, and that death occurred at 2:00 AM from the causes and on the date stated above.

ACTUAL SIGNATURE: Robt Barthel M.D. ADDRESS (Street, city or town, state): Forest Hill, Md. DATE SIGNED: 9/9/60

PHYSICIAN'S NAME (Type): Robert A. Barthel Jr. M.D. Forest Hill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 9/10/60
22c. NAME OF CEMETERY OR CREMATORY: Boone Cemetery
22d. LOCATION (City, town, or county) (State): Boone North Carolina

23. FUNERAL DIRECTOR'S SIGNATURE: John G Tarring ADDRESS: aberdeen, maryland
24a. REC'D BY REGISTRAR DATE: SEP 14 '60
24b. REGISTRAR'S SIGNATURE: Arthur S Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10343

CERTIFICATE OF DEATH

Reg. Dist. No. 10338

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 569 Revolution Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Aberdeen
d. STREET ADDRESS: Box 26
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RICKEY — Middle NELSON — Last WARFIELD

4. DATE OF DEATH: Month September — Day 16 — Year 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 1, 1959

9. AGE (In years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Mn

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gideon Warfield

14. MOTHER'S MAIDEN NAME: Eva Kenly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT: Eva Warfield, Aberdeen, Md. — Address: Box 26,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Viral Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Gastroenterocolitis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 571.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour o. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 13, 1960, to Sept. 15, 1960, that I last saw the deceased alive on Sept 15, 1960, and that death occurred at 10:00 a.m. p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: George T. Stansbury M.D.
ADDRESS (Street, city or town, state): 569 Revolution St.
DATE SIGNED: 9/17/60

PHYSICIAN'S NAME (Type): George T. Stansbury, M.D. — Havre de Grace, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9/19/60

22c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cemetery,

22d. LOCATION (City, town, or county) (State): R.D. Aberdeen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring
ADDRESS: Tarring Funeral Home, Aberdeen, Md.

24a. REC'D BY REGISTRAR — DATE: SEP 22 '60

24b. REGISTRAR'S SIGNATURE: Cathryn L. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10344

CERTIFICATE OF DEATH

10339

1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE
c. LENGTH OF STAY IN 1b 1 HOUR
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BEL AIR X RD # 3
d. STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: ALICE Middle: LOUISE Last: WELCH

4. DATE OF DEATH Month: SEPTEMBER Day: 26 Year: 19 60

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: APRIL 18 1898
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BANK CLERK
10b. KIND OF BUSINESS OR INDUSTRY: BANK
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: B. FRANKLIN WELCH
14. MOTHER'S MAIDEN NAME: ELIZABETH WAYSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. YES
17. INFORMANT: JACK GORDON BRIGHT Address 701 REGISTER, RD. BALTO. 18 MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation, Acute — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) A.S.C.V.D. — ?
DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 25th 1960 to Sept. 26th 19 60 that (I) ~~(we)~~ last saw the deceased alive on Sept. 26th 19 60 and that death occurred at 1 A.M. from the causes and on the date stated above.

22a. SIGNATURE Edward C. Loo, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 9/26/60
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.
22d. ADDRESS Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION
23b. DATE THEREOF SEPT. 26 1960
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM.
23d. LOCATION (City, town, or county) (State) BALTO MD

24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell ADDRESS HAVRE DE GRACE MD
25a. REC'D BY REGISTRAR DATE SEP 27 '60
25b. REGISTRAR'S SIGNATURE Arthur L. Timms

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10361 Items 8,9 FilmG273 10-17-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 10340

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Rock Pa
c. LENGTH OF STAY IN 1b 6 mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home Near Norrisville

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa Md
d. STREET ADDRESS Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Wilder

4. DATE OF DEATH Month Sept Day 29 Year 1960

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH April 16 1890 1891

9. AGE (If years last birthday) 69 70 yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ewing — Va

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Robt Wilson

14. MOTHER'S MAIDEN NAME Mary C. Long Ewing Va.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. none

17. INFORMANT Address Lillian Middlebrook Fawn Grove Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma Bones Lungs — Interval between onset and death: 6 mos
DUE TO
(b) Primary Carcinoma Uterus — 1 yr.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

174X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 1, 1960, to Sept 29, 1960, that I last saw the deceased alive on Sept 28, 1960, and that death occurred at 1:15 p. M. from the causes and on the date stated above.

ACTUAL SIGNATURE William O Fulton M.D. ADDRESS (Street, city or town, state) Stewartstown, Pa. DATE SIGNED 9-29-60

PHYSICIAN'S NAME (Type) William O Fulton Stewartstown, Pa.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF Oct 3 1960

22c. NAME OF CEMETERY OR CREMATORY Mountain Christian

22d. LOCATION (City, town, or county) Joppa (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W H Archer Benson Md

24a. REC'D BY REGISTRAR DATE OCT 4 '60

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55